

ST. BARTHOLOMEW'S HOSPITAL JOURNAL



Vol. LXIV, No. 10

OCTOBER, 1960

Calendar

November

- Sat. 5—On duty: Dr. G. W. Hayward
Mr. A. W. Badenoch
Mr. R. W. Ballantyne
R.U.F.C. Cornish Tour
- Mon. 7—Film Society: "High Society"
- Tues. 8—Squash v. Stonyhurst Wanderers
(H) 6.30.
- Wed. 9—A.F.C. v. St. Thomas's Hos-
pital (H)
- Thurs. 10—Abernethian Society: Professor
Peart—"Hypotension"
- Sat. 12—On duty: Dr. E. R. Cullinan
Mr. E. G. Tuckwell
Mr. C. Langton
Hewer
R.U.F.C. v. Old Haberdashers
(H)
A.F.C. v. Middlesex Hospital
- Tues. 15—C.U. Open meeting—Recrea-
tion Room, Charterhouse, at
5.45 p.m.
Squash—Cumberland Cup
- Wed. 16—A.F.C. v. St. Mary's Hospital
(H)
- Sat. 19—On duty: Medical and Surgical
Units
Mr. G. H. Ellis
R.U.F.C. v. Old Alleynians (H)
A.F.C. v. Warham Med. School
(H)

- Mon. 21—Film Society: "Jour de Fête"—
Jacques Tatis
- Tues. 22—Squash v. Middlesex Hospital
(H) 6.30.
- Wed. 23—A.F.C. v. Westminster Hospital
(H)
- Thurs. 24—S.U. Council Meeting & A.G.M.
- Sat. 26—On duty: Dr. R. Bodley Scott
Mr. A. H. Hunt
Mr. F. T. Evans
R.U.F.C. v. U.S. Chatham (H)
A.F.C. University Cup
- Tues. 29—Squash—Cumberland Cup
- Wed. 30—S.U. Council Meeting
- December
- Thurs. 1—Abernethian Society: Sir John
Wolfenden—"Crime and Sin".
College Hall at 5.45 p.m.
- Fri. 2—C.U. Service at St. Bartholo-
mew-the-Less, 1.00 p.m.
R.U.F.C. Annual Ball
- Sat. 3—On duty: Dr. A. W. Spence
Mr. C. Naunton
Morgan
Mr. R. A. Bowen
R.U.F.C. v. Old Cranleighans
(A)
- Mon. 5—Film Society: "Scott of the
Antarctic"
- Tues. 6—Squash—Cumberland Cup
- Wed. 7—A.F.C. v. London Hospital (A)

Editorial

NOBODY is able to say what a hospital ought to look like. We are all very proud of the Square but in many ways the buildings which surround it are as unsuitable as any in the City for the practice of medicine. An aesthete (distinguished enough) has already suggested that the new L-block is almost devoid of architectural merit. Those who will use it may well find the lifts in the wrong place or the central heating inadequate. Of the standards by which a hospital can be judged, the most important are often those which are altering. The changing pattern of disease and morbidity alone, present the planners with a task which is hardly equalled elsewhere.

Modern design is influenced by space, neighbouring buildings (including churches!) and building materials in addition to the estimated requirements of the building. It is true that all these have been important in the past but the speed with which changes have occurred in medicine accentuate the importance of each. So much so that it seems that hospitals may not in future be designed in the traditional way as a single unit. Professor Llewelyn Davis goes so far as to say that "the hospital of the future may perhaps draw architectural inspiration from the size and shape of the functional units within it".

With this in mind and also the universal shadow of finance, Lord Taylor has suggested that a master-plan could be drawn up and consulted by hospital planners. Many, and especially those who believe that the modern ward will be replaced by acute, highly staffed, units and convalescent units and day treatment centres, think this plan impracticable. It does serve, however, to emphasize the need to study changing patterns of disease and morbidity in conjunction with design.

The ideal was perhaps experienced by us all when we were very young and were able to build with packs of cards. Not only was it easy to build up and pull down at will but the time between forming our plan and seeing our castle of cards was short enough to be reasonably certain that our mood had not changed. There was plenty of space too.

When we look around and see the extensive building programme being undertaken in the Hospital it is interesting to compare what we see with what we have come to expect of hospital buildings as a result of

recent writings. It would seem difficult to think of any of it in terms of a master-plan. Indeed in many ways freedom to experiment is more important than evolving a plan which might later slow our ability to meet changing needs. Those who have had their own ideas incorporated into a building will enjoy using it and also the freedom.

Fifty Years Ago

"The Surgical Side of the Hospital Fifty Years Ago" was the title of an article contributed to the Journal of 1910 by Alfred Willett F.R.C.S., who, at that time, was one of the Consulting Surgeons to the Hospital.

It was in October 1860 that Willett took up his appointment as house surgeon to Mr. Lloyd. In those days the house surgeon held office for a year, and worked single-handed, for it was not until 1882 that junior housemen came into being. For reasons of ill health, Mr. Lloyd retired early in 1861, and his place was taken by Mr. Wormald.

Thursday was admission day for in-patients, so at twelve the house surgeon had to hurry across to the Steward's Office to investigate the complaints of the surgical cases assembled, whilst Mr. Wood—the apothecary—did the same for medical cases. The office was usually fairly packed; few of the many patients were suitable for admission, their maladies being of the chronic type, ulcers of the leg predominating.

At 12.30 the physician and surgeon of the week would arrive. The surgeon would ask his house surgeon what cases he thought were suitable for admission, such as a tumour of the breast, a lipoma, or joint diseases. These being admitted, the remainder would be called up in turn, quickly examined, two or three more perhaps, looked upon with a more discerning and lenient eye by the surgeon, and passed for admission. The rest would be dismissed on one plea or another.

Each surgeon had five dressers, and though they were not required to take notes of the ward-patients assigned to them, they were, nevertheless, very fully engaged over the "dressings", for, practically speaking, all wounds of both operation and accident cases suppurred freely. Indeed it may be added that they were both expected and induced to heal by this method of "secondary intention" as it was called. That operation

wounds were bound to suppurate is proved by the routine in vogue.

To start with, each surgeon and assistant-surgeon had an operation coat, kept in a cupboard in the theatre; this in time became coated with dried blood and other discharges, and, like some tattered old flag, the more foul it became, the more honoured and treasured it was to its owner. Sponges were only casually cleansed by rinsing in water, and would do for a series of operations. Then, again, all bleeding vessels were tied with dry silk ligatures, unprepared, just as received from the manufactory, one end only being cut off, the other left long, so that when the wound was closed, a dozen or more threads were brought out between the sutures to "fall" as it was called when they became loosened by ulceration. After 48 hours the first dressing took place, and almost to a certainty either a bread or linseed poultice was ordered. Operation wounds would take from three weeks to three months in healing. Pyaemia too often marred the apparent well-doing. The advent of the tenth day was anxiously watched; despair settled on all at the dreaded summons: "Please sir, will you come to — —, he has had a rigor." This, in about 48 hours would be followed by another, and then, in succession at short intervals, joint after joint would be found hot, swollen and painful, whilst cough and hurried breathing told, only too obviously, of the lungs being involved, and death usually supervened in about a week from the first rigor.

Excepting emergencies, all operations were performed on Saturday afternoons. A few incidents which happened are impressed on my memory. On one occasion Mr. Lloyd had a lithotomy, his plan for this operation being to plunge a bistoury from the centre of the perineum directly into the rectum and cut straight out along the middle line (not infrequently the operator would be deluged in a spray of liquid faeces); then, cutting into the groove on the staff, he reached the bladder in the usual way. On the occasion in question, the stone had been struck before commencing, but could not be found even after a prolonged search, and at length the boy was sent back to bed. The next morning, however, the nurse found the stone in the bed. It was surmised that the small calculus escaped from the bladder at the end of the first gush of urine, slipped unobserved into the rectum, getting caught in a fold of

mucous membrane where no one dreamt of looking for it.

It might be added here, that another surgeon, Mr. Skey held that no one should take more than half a minute for a lithotomy, which necessarily means that each stage of the operation had to be completed with the utmost rapidity.

The sisters of Abernethy or Lucas wards, according to the sex of the patient, attended the theatre at all operations. Sister Abernethy of the time was a really splendid character, immensely respected by all. Another noted sister on the surgical side was "Colston" to whom the nickname "Queen of Hell" was most unjustly given. The fact was she looked upon complaints by a patient as base ingratitude. Yet to see her every morning in the square, outside her ward, surrounded by a flock of city pigeons, which she regularly fed, settling on her head, shoulders or arms while she carressed them, showed she had at least one soft spot in her heart.

The article ends with a brief paragraph: "I fear the foregoing will not be so intelligible to many as I could wish, but without going into details, which would be tedious, it is difficult to compare the work and duties of past times with those of the present day. One characteristic of the past still remains, and will do so—I mean the affection which all connected with the hospital bear towards it."

News in Brief

It is with deep regret that we record the death of SIR HAROLD GILLIES. An obituary notice will appear in a subsequent issue.

SIR WILFRID LE GROS CLARK, F.R.S., has been elected president of the British Association for the Advancement of Science for the year 1961.

SIR JAMES PATERSON ROSS is to give the Thomas Percy Legg Lecture at King's College Hospital Medical School on Friday, Oct. 14, at 4.30 p.m. He will speak on the Principles of Surgery.

Professor M. de B. DALY has received the degree of Sc.D. from the University of Cambridge.

The Governors have approved an extension to the Radiotherapy Block. Plans are now being drawn.

Wessex Rahere

The Autumn Dinner of the above Club will take place on October 29th, 1960, at the Grand Spa Hotel, Clifton, Bristol, under the Chairmanship of Dr. Russell Grant, of Winchester. It is hoped that the Guest of Honour will be Dr. Heber Langston. Further details will be circulated or can be obtained by any Bart's graduates who are not already members from the Hon. Secretary, Mr. A. Daunt Bateman, F.R.C.S. 11 The Circus, Bath.

Births

BUTTERY.—On September 2, to Penelope and Dr. David Buttery, a second son (Jeremy David).

ELLISON.—On September 3, to Heather, wife of Dr. Anthony J. H. Ellison, a son Paul (Anthony Hereward).

Engagements

MCKINNA—FOREMAN.—The engagement is announced between Dr. Colin McKinna and Barbara Cynthia Foreman.

PARKES—WHATLEY-WHITE. — The engagement is announced between Dr. J. David Parkes and Elizabeth K. Whatley-White.

TRESSIDER—KARK.—The engagement is announced between Valentine C. Tressidder and M. R. Kark.

Deaths

FOSTER.—On September 3, Lt. Col. Raymond Leslie Vachel Foster, R.A.M.C. (retd.) aged 86. Qualified 1901.

GASKELL.—On September 11th, Dr. John Foster Gaskell, M.D., F.R.C.P., D.P.H., aged 82. Qualified 1907

GILLIES.—On September 10th, Sir Harold Gillies, C.B.E., F.R.C.S., aged 78. Qualified 1908.

SEWELL.—On August 31, Col. Evelyn Pierce Sewell, C.M.G., D.S.O., M.B., aged 86. Qualified 1899.

Change of Address

Dr. L. J. Forman Ball, Bond's Cottage, New Street, Lydd, Kent.

“FIRST CATCH YOUR HARE”

by Malcolm Donaldson, F.R.C.S., F.R.C.O.G.

IN an old edition of Mrs. Beeton's cookery book there is a recipe for “Jugged Hare” which starts off, “First catch your hare”. This advice is equally applicable to medical men or women who hope to cure patients of malignant disease. Every student realizes the importance of “early stage diagnosis” in the prognosis of cancer treatment, but may confuse this with “early diagnosis”. It may be as well therefore to point out that “early diagnosis” means the discovery of the growth as soon as symptoms are noticed, but in some cases the growth is already in a “late stage” and disseminated. There is no doubt however that the more “early diagnoses” that are made the more likely it is that more “early stage tumours” will be found.

Accessible Cancers

The following are generally labelled the accessible cancers — breast, uterus, rectum,

bladder, mouth, larynx, lip and skin. These do as a rule show symptoms whilst in an “early stage” but alas are often neglected as is shown in figures from the Registrar General's Report 1957. The mean delay between a patient noticing a painless lump in the breast and seeking advice is 6.2 months and 17.3 per cent of all cases wait over two years, believing that if there is no pain or tenderness, it cannot be serious.

In cancer of the uterus (cervix) the mean delay is 5.7 months, but 8.4 per cent wait over two years. This of course is due to the fact that irregular bleeding between the periods and particularly during the menopause is so common and generally due to some endocrine disturbance. The dreadful phrase “only the change of life” is responsible for thousands of deaths. One woman discusses her trouble with a neighbour, who says “don't you worry my dear, it is only

the change, I had to go through it," and the younger woman being reassured by her foolish elderly neighbour neglects to take advice, possibly with disastrous results. In malignant disease of the rectum the delay is 5.4 months and 25 per cent wait over a year. This of course is due to the fact that the patient thinks it is "only a touch of the piles" and goes to the chemist week after week for "pile ointment".

Not only are these long delays due to ignorance but also to fear. It is not necessary to be a psychiatrist or a psychologist to realise this. Cancer is surrounded by a psychological atmosphere like no other disease, I call it "Cancer Smog".

It would seem that there are three types of this "Cancer Smog". First, true cancerphobia. This is probably rare in this country, and the diagnosis should only be made when a patient is so obsessed with the fear that it interferes with his or her way of life and should be treated by a psychiatrist. A few commit suicide; one was reported in Bedford recently and also in Reading.

In spite of the rarity of "cancerphobia", nearly 100 per cent of the adult population have a lesser or greater "cancer apprehension". This again is of two types.

(1) *Personal Apprehension*. By this is meant a person who has some symptom for which it is difficult to account, e.g. a woman with some pain in the breast, and she immediately thinks "can this be cancer?" Possibly she will speak to no one but worry for weeks or months until the pain disappears. She may go to the doctor but not mention her fears, and therefore gets no reassurance, and returns week after week, only to be considered a "neurasthenic" when the real diagnosis is a "cancer apprehensive".

Some do speak of their fears, only to be good naturedly laughed at. The patient goes away determined never to mention the word cancer again but goes on worrying. On more than one occasion at the end of a lay lecture I have been told "it is no good going to doctors about cancer, they won't tell you the truth". This lack of confidence in the G.P., but only in connection with cancer, has been increased recently, by a senior medical man writing to the lay press and saying doctors should deceive their patients.

During many years in the out-patients I used to manage such apprehensive patients by examining them carefully and then say-

ing, "I am glad to say there is nothing serious and no evidence of *cancer* emphasizing the word cancer. To which the reply was very frequently "Thank God, that is what I really came about". If this line was taken by more family doctors, and then a few words spoken about the early symptoms, the time spent would be refunded by such patients keeping away from the surgery. Of course, such patients are not so easy to spot in general practice as in gynaecological O.Ps.

(2) *Impersonal Apprehension*. By this is meant fear that by speaking to a person about cancer, will cause fear or increase fear in the person addressed. This type of apprehension is very common, and does a great deal of harm because it keeps up the "Hush Hush" and conspiracy of silence. This prevents patients from visiting a doctor at a time when the disease may be in an early stage. There is considerable evidence of this kind of apprehension.

When the C.I.A. was first started pamphlets in stamped envelopes were given to people to address and post to their friends, but they refused on the grounds that their "handwriting might be recognised". The same people however would give me the names and addresses of their friends, in one case 30, to send out.

How then can this fear be diminished? It can only be done by bringing the fear to the surface and encouraging people to face facts and to talk about cancer as they already talk about other serious disease, e.g. heart disease, which kills twice as many people per year as cancer, in fact the object should be as someone put it "to make cancer ordinary".

In this country a Cancer Education Campaign can best be organized by the Local Health Authorities, and indeed the 1946 Act puts the responsibility for "all medical education of the Public" on them. Every individual, however, can help by discussing the disease frankly and freely. "Knowledge is the antidote to fear" wrote Emerson, and he was correct.

Diagnostic Centres

Owing at present to the reluctance of some patients to visit their own doctor if they suspect the possibility of malignant disease, some people advocate centres to which anybody can go without symptoms. This is popular in the U.S.A. and the Strang Clinic

in New York is the best known of these. At one time they were common in Canada, but have now been given up. The arguments against such centres is overwhelming. The number of unsuspected cases without symptoms found is very small and requires a great many man and woman hours to discover them; this is more important than the money spent. It also means duplicating all the apparatus, X-rays, etc. Regular overhauls are ideal, as for motor cars, but at present not possible in this country under the N.H.S. It is true that such a centre would have the psychological advantage that the patient would be able to get an overhaul without having to face the family doctor, but it must be clearly understood that such an examination can only exclude some of the accessible cancers, breast, uterus, rectum, etc., with reasonable certainty. This at present can only be done by paying a fee.

For the present patients should be sufficiently informed so that they will go to their doctor if certain symptoms appear. The family doctor should be given better facilities for diagnosis, e.g. smears, etc., as they are in Edinburgh, and perhaps better post-graduate instruction on the diagnosis of "early stage" cancer. If the doctor has any doubt he should be able to send the patient to the hospital *next day*, where the patient should be seen by a *team* of consultants who *meet each day* except Sundays. Cancer is a greater emergency than an "appendix" because some of the latter do recover without treatment, cancer never.

The Profession and Cancer Education

In 1953 a questionnaire was sent by the B.E.C.C. to all family doctors (consultants for some unknown reason were not included), asking them if they believed in "cancer education" among the public, and they were to reply *Yes* or *No*; people were not allowed to have any doubts. As very few doctors had any experience of such education only 25.4 per cent replied and of these 14.1 per cent said *No*, and 11 per cent said *Yes*. Since 74.6 per cent abstained, the figures were statistically useless. Since that date the "Wind of Change" at present only a light breeze, has passed through the profession, and one well-known surgeon has published his conversion in the B.M.J. At present few are antagonistic, but many are apathetic.

What then are the arguments used against such an educational campaign. First the

psychological effects, i.e. the belief that it will create fear. At the International Cancer Conference 1958 in London, the representatives of every country who discussed this subject denied that it had increased fear or apprehension or that it had increased the work of the doctors or crowded the surgeries. This has been the experience in the Manchester area where out of 108 doctors asked whether the cancer talks ever caused them any additional work or brought patients to their surgeries without observable symptoms the answer was *No*, 105, and *Yes*, 3. My own figures collected during a pilot experiment in Yorkshire where the following printed ballot paper was distributed at the end of each lecture, pointed the same way.

Some people have suggested that lectures such as you have just heard do no good, and indeed may do harm. Please state quite frankly what effect it has had on you, by putting an X against the statement (i) if you think it has increased your worry and that such lectures should not be given; or against (ii) if it has helped you and you think more such lectures should be given. If you are doubtful put a ? instead of an X.

(i) It has increased my worry and such lectures should not be given

(ii) It has relieved my mind and is helpful. More such lectures should be given

Of 5,740 votes, 99.1 per cent were in favour, 0.2 per cent against and 0.7 were doubtful.

Statistical Objections. A definition of a statistician is "a man who takes great trouble to collect accurate figures for other people to misuse and to misquote". It has been said that statistics can be made to prove anything, but the truth is that without statistics nothing can be proved. The profession justifiably asks if it can be shown that it has affected the mortality figure or the five year survival rate. In this country the answer is *No* because hardly any cancer education has been carried out, but there are some suggestive figures in other countries. Every statistical table proves beyond doubt that clinical "early stage cases" have a better prognosis than late stage cases. It is therefore only necessary to prove that cancer education produces more "early stage" cases. There are suggestive figures from Manchester but at present the investigation has not been carried out on a large scale. It can be done as I showed in my report on the Yorkshire Pilot Experiment.

The following figures have been used to show that delay does not matter.

<i>Delay in months after symptom noticed</i>	<i>Five-year Survival</i>
0—3	44 per cent
4—6	39 per cent
7—12	41 per cent
24+	44 per cent

Such an argument is futile, a comparison is being made between entirely different types of growth. The cases treated in the first three months are mostly quickly growing early disseminating tumours, whereas those of two years' duration are entirely slow growing tumours, a selection by death. Between the two extremes there are all degrees of growth rate, and many of these 54 per cent who died in this series might have been saved by earlier treatment. Of course there are many individual cases who have to my knowledge consulted a doctor after hearing a lecture or reading a pamphlet. Sometimes it is said that doctors and nurses are the worst offenders about seeking advice concerning suspicious symptoms. Statistically this is not true, but any such case is remembered by a consultant, who never remembers the hundreds of delayed patients that pass through his hands, and possibly does not even ask how long the symptom has been present. When, however, a professional person does delay it is probably often due to fear lest they should be considered a case of "cancerphobia" or a "neurotic" by their colleagues.

Should the doctor tell?

Every student who takes up general practice will meet on the average about 15 new cases of cancer each year, but although small in number they will be the most worrying of all his or her cases. The problem of what to tell a patient is only *indirectly connected* with "cancer education" which is devoted to people who are *quite healthy*.

The present principle generally adopted is "Tell the relatives everything, the patient nothing". As a principle there are many arguments against such a procedure.

1. Every patient is not a mental defective, and when he or she realises that their condition is getting worse, it will be very difficult, if not impossible, to keep up the decep-

tion. Some may pretend to be deceived in order to comfort their relatives or doctor.

2. Having realised that he is dying of cancer, the patient will blame the doctor for not diagnosing the real condition earlier which has been camouflaged as "rheumatism" or some other disease.

3. If in later years a relative of the deceased thinks that he may have cancer, it will be difficult to convince him otherwise, because he knows the doctor deceived or tried to deceive his dead relative. This loss of confidence is very serious.

4. Aitken-Swan and Eason in 1959 stated that in a survey carried out in the Manchester area only 7 per cent resented being told that they were suffering from or had had cancer, so it is obvious that most patients prefer to know the truth rather than to remain in doubt. In hospital many patients, if they have not been given a definite diagnosis, assume that they have cancer.

5. If patients who have recovered from cancer are never told, the belief that no case is ever cured will persist, and any patient who suspects the possibility that he is suffering from cancer will consider that there is no object in going to a doctor.

For these reasons it is far better whenever possible, particularly when a patient has been cured, that the "doctor should tell". This can be done gently without causing much shock because the patient generally suspects it already. The prognosis given should be as optimistic as possible; *it is criminal to take away hope*. It is also foolish to give a poor prognosis, as on more than one occasion the patient has outlived the doctor who has given such a prognosis.

Far too many practitioners take a completely fatalistic view of the disease, and refuse even to attend a lay lecture in order to observe the reaction of the audience, on the grounds that they "have not got the time". Has not the time arrived when somebody should *find time to think about the "early stage" diagnosis of cancer?* The disease in this country kills 100,000 people per year, the greatest killing disease next to cardiovascular disease.

If cancer education could be carried out properly throughout the country, it would probably add 10,000, i.e. 10 per cent to the 30 per cent five year survival rate at present existing, and perhaps more important, would bring comfort to millions of people.

WILLIAM SMELLIE

by Elizabeth Knight

Part I of the Wix Prize Essay 1960, to be concluded.

His Time

IT was the beginning of the Age of Reason —so the eighteenth century has been described. The medical historian, Dr. Charles Singer, sees it as an Age of Consolidation in the evolution of the study of medicine. Much had happened in the two preceding centuries and methods of learning had altered. The study of science was itself becoming a science, not least through the influence of Isaac Newton.

This great man had proved that the Natural Law was universal and scientists were anxious to show its existence in every branch of learning. Progress was rapid and time was needed to sort out the wealth of material at hand.

Another desperate need in the field of medicine at this time was to improve medical education. Until the seventeenth century there had been little at any of the universities. Leyden in Holland was the first to establish a course, and in 1660, Sibbald, a student at Leyden, returned to his native Scotland and founded the Royal College of Physicians of Edinburgh. Thus Scotland, too, became a pioneer in the improvement of medical education.

This then was William Smellie's context, a century which marked a change in the scientific outlook, a country on the threshold of great cultural achievement, and a county, Lanark, which, within the short space of thirty years was to produce four great medical men, Smellie, Cullen, founder of the Glasgow University medical school, and the brothers William and John Hunter. It was certainly auspicious.

Youth and Education

The year of William Smellie's birth, 1697, is recorded only on his tombstone in the churchyard in Lanark where he was buried.

He was the son of Archibald and Sara Smellie. Archibald was made an Elder of the Parish church of Lanark at the Kirk Sessions of 1727. Elders of the Kirk were valued men who took their duties most seriously. Sara was related to a family of small landowners and must therefore have been quite well to do. From this one may deduce that William had a good Christian upbringing in a respected Lanark family.

Smellie went to the grammar school in Lanark which, at this time had a fine reputation. In a "letter of exculpation" written after his retirement to Dr. Pitcairn of St. Bartholomew's Hospital, he says of himself that he was "very idle and dull at school and was taken more up with carving and painting than books". However, he must have had an affection for his *alma mater*, because he left to the school his precious collection of books, which is still housed in Lanark.

Of his medical education little is known. At this time, however, there was no organised curriculum and the best education was to be had at Leyden or Paris, or by apprenticeship to a practitioner at home. As no formal qualification or degree was required this last was probably quite adequate.

McClintock, who edited the New Sydenham Society's edition of Smellie's works, says that "the registers of the Universities of Edinburgh, Glasgow, St. Andrew's, Leyden, Utrecht and Aberdeen have been examined with a negative result; but I have been informed that the registry of St. Andrew's is defective for some years about the time when Smellie's name would appear in it; so that he may have taken his medical degree in this University, and from not finding his name elsewhere, I am disposed to think that he did".

This, too, is somewhat negative evidence and Glaister, Smellie's first biographer, thinks it equally likely that Smellie in fact chose apprenticeship, under Dr. Gordon of

Glasgow. The evidence for this is that in later years the two were certainly close friends, and that Tobias Smollett, the novelist and friend of Smellie was indeed apprenticed to Gordon and might well have introduced the two men. Gordon was a Glasgow physician of some repute, who eventually became President of the faculty of Physicians and Surgeons. Later when writing of his debt to those who had helped him, Smellie says, "In particular I was obliged to Dr. Gordon of Glasgow, and Dr. Inglesh, of Lanark in Scotland; the first made me acquainted with the blunt hook, the other with the noose".

At all events, Smellie returned to practise in Lanark in 1720. Lanark, then, was a small town with a population of about two thousand, but it was also the county town, and an important centre of the wool trade.

The Lanark Doctor

Attempts were afterwards made by Sir James Young Simpson and others to belittle Smellie during his years at Lanark. At a meeting of the British Medical Association in Edinburgh in 1858, Sir James said of Smellie, "While settled at Lanark, he did not succeed, as we learn from one of his subsequents detractors, in getting above the position of second medical practitioner in that small community, and I have seen some of his accounts showing how miserably small his fees were. In fact he eked out his scanty income by keeping a shop as a village cloth merchant as well as by practising as a village doctor".

However, there is no evidence that this story was true, and a bill of 1723 in which "seven pound sterling" was named as the "agreed wages and fee for Amputation and Cure of your leg, performed by me in harvest last. Make thankfull pay^t and oblige your humble serv^t Wil. Smellie," belies the "scanty income" referred to by Simpson.

While in Lanark he read widely in the medical and obstetric literature of the day, and borrowed books on Medicine and Surgery from his friend William Cullen. In a letter to Cullen he says, "I have kept your book on Consumption too long, but I shall send it next week. Send me up Dr. Clifton's history of Medicine, I want to see something in him. I could not get that book from Glasgow or Edinburgh, but I have sent to London for it".

Smellie's was a "general" practice although this tends to be forgotten as only his notes on obstetric cases are extant. These he preserved until he wrote his great work, the "Treatise on the Theory and Practice of Midwifery". In case 186 he records some general notes on his methods at this time.

"During the first year of my practice when I was called to lingering cases, which were often occasioned by the imprudent methods used by unskilful midwives to hasten labour, such as directing the patient to walk about and bear down with all her strength at every trifling pain until she was quite exhausted, and opening the parts prematurely, so as to produce inflammations, and torture the woman unnecessarily; on such occasions, without knowing the steps that had been taken, I have been told that the patient had been in severe labour for many hours, and sometimes days, and that now I was called to prevent her from dying with the child in her belly. Thus solicited, if the head was at the upper part of the pelvis, I commonly turned the child and brought it by the feet; and thus if small, it was usually saved, provided it was not dead before my arrival; but when the head was large, or the pelvis narrow and distorted, the force necessary to extract it was often the occasion of its death.

"On the other hand, when the head was so low in the pelvis that I could not raise it into the uterus in order to be turned, I was obliged to dilate the cranium with my fingers, assisted by the blunt hook. This method, however, I never practised except when the head was low down and the patient so much exhausted that she could not be delivered by the pains; and not even then, until after I had tried Mauriceau's fillet which always failed, and another, introduced by my fingers in the form of a noose, which sometimes, though, very rarely, succeeded when the child was small."

Some time during his nineteen years in Lanark he married Eupham Borland, and everything suggests that the marriage was a happy one though without issue. They were the likely originals of Dr. and Mrs. S. in Tobias Smollett's novel "Peregrine Pickle".

In 1733 he was admitted to the faculty of Physicians and Surgeons of Glasgow—his first medical qualification after thirteen years of practice.

To London via Paris

In 1739, Smellie gave up his practice in Lanark and after a few months, settled in London. What led him to take this radical step? Again case 186 comes to our aid and hints at the answer. He says:

"In order to avoid this loss of children, which gave me great uneasiness, I procured a pair of French forceps, according to a draft published in the Medical Essays by Mr. Butterm, but found them so ill-contrived that they by no means answered the purposes for which they were intended. I afterwards perused the treatises of Chapman and Giffard, who had frequently saved children by a contrivance of this kind; and actually made a journey to London in order to acquire further information on this subject."

His intention in going to London was, then, to see if anyone there could instruct him in the use of forceps. While there he presumably listened to such teachers as there were, perhaps Sir Richard Manningham or John Maubray. But of London he says: "Here I saw nothing was to be learned: and I therefore proceeded to Paris, where courses on midwifery were at that time given by Grégoire."

There were in fact two Grégoire's, father and son. Smellie's biographer, Glaister, concludes that it was the younger to whom he went. Of Paris he says: "There likewise I was very much disappointed in my expectation." However, in Paris he did see the machines or "dummies" which were used in instruction. He became very interested in these and thought that he could better them. He says:

"Though his method might be useful to a young beginner, his machine was no other than a piece of basket-work, containing a real pelvis covered with black leather, upon which he could not clearly explain the difficulties that occur in turning, proceeding from the contractions of the uterus, os internum and os externum. And as for the forceps, he taught his pupils to introduce them at random and pull with great force, though he preferred Chapman's instrument to that used by the French, and recommended the improvement made upon Mauriceau's fillet, which can never be of any use.

Little satisfied with his manner of instructing, I considered that there was a possibility of forming machines which should so exactly imitate real women and children as to exhibit to the learner all the difficulties that

happen in midwifery; and such I actually contrived and made by dint of uncommon labour and application."

And so Smellie's path was finally directed to obstetrics and he returned to settle in London.

Teacher of Midwifery

Smellie set up first in Pall Mall as an apothecary and practitioner of midwifery. After some while, William Hunter came to live with him and studied under him. Smellie refers to him in some of his notes as having been present and assisted at certain deliveries. At this time, Smellie applied himself to his "machines" and to attending courses of lectures in various subjects. As he says:

"I endeavoured to reduce the art of midwifery to the principles of mechanics; ascertained the make and shape and situation of the pelvis, together with the form and dimensions of the child's head."

It was thus, into the mechanics of child bearing that Smellie enquired and it is significant that both critics and protagonists were united in their admiration of his ingenuity. A student described him as "an uncommon Genius in all sorts of mechanicks, which after having shewed itself in many other improvements, he manifested in the machines which he has contrived for teaching the Art of Midwifery . . . They are composed of real bones, mounted and covered with artificial Ligaments, Muscles and Cuticle, to give them the true Motion, Shape and Beauty of natural Bodies, and the contents of the Abdomen are imitated with great Exactness". He also had several foetuses so that he was able to demonstrate all kinds of presentation and delivery.

On the other hand, Mrs. Nihell, a midwife, who delivered a bitter attack upon Smellie, is driven to admit that, "By this admirably ingenious piece of machinery were formed and started up an innumerable and formidable swarm of man midwives".

"On Monday, 14th June, at 5 p.m., will begin a course of lectures on the theory and practice of Midwifery at 11 a.m. for women, and 3 p.m. for men, by Mr. Smellie, at his house in the New Court, formerly the Key and Garter tavern over against St. Albans Street, Pall Mall." So runs the earliest advertisement of Smellie's classes, which appeared in the "London Evening Post" of June 1st, 1742.

The course comprised lectures and demonstrations on the models, and teaching on actual cases. Smellie offered free attendance on poor women on condition that he might bring his students with him.

The cost of a two months' course was seven guineas, that of a six months' course fifteen guineas. In addition, McClintock tells us, each student had to pay ten shillings for a case and six shillings into a common fund which Smellie dispensed to the more needy of his patients.

Dr. Peter Camper, the Dutch anatomist, who had graduated in philosophy and medicine at the University of Leyden in 1746, enrolled in Smellie's class in January 1749. He too, had been dissatisfied with the type of obstetric forceps then in use, and having heard of Smellie's teaching he came to London to see for himself. Camper made notes from Smellie's lectures, which are in accordance with what Smellie wrote later in the *Treatise*, and he gives a good account of Smellie's teaching.

"He (Smellie) explains the osteology of the pelvis in both a healthy and in a morbid and misshapen state. He explains both their external and internal parts by using the dead bodies of women but much more clearly in other exhibits specially prepared for the purpose.

"He demonstrated parturition in models of women of which the pelvis and spine of a well-modelled woman are the starting point. Both the abdominal and extra-abdominal parts have been made out of leather with such remarkable skill that not only is the structure as natural as possible but the necessary functions of parturition are performed by working models."

During a second visit to London, Camper makes a note on antenatal examination. This is of especial interest as there was very little clinical teaching during the antenatal period.

"I attended Smellie's lesson and examined twenty-one pregnant women between seven and nine months. I was always able to identify the head above the os pelvis, in the ninth month it was low in the pubis. The orifice of the uterus was in all cases turned back against the os sacrum, in some it was open, and it was easy to put one finger sometimes two in."

Camper's notes are invaluable for their own sake and because they show that what Smellie had to offer his pupils in 1750 can still be learned today in his great work, "*The Treatise on the Theory and Practice of Midwifery*", and in his "*Sets of Anatomical Tables*".

THE QUESTIONNAIRE

The Student and Emigration

by J. S. Price

IN the June *Journal* Mr. E. A. J. Alment presented a summary of the findings of the Questionnaire sponsored by the Journal Committee. This article is one of a series which deal in more detail with particular aspects of the findings, and which include the results of correlations calculated by the Tabulating Research Centre.

The Questionnaire was circulated to all Bart's students in December 1957, and was answered by 377 (85 per cent) of them. It was made clear at the time that the Questionnaire was anonymous, and that it was the basis of a serious study; in fact, only one of the answer papers included remarks which could be construed as amusing. The

validity of the Questionnaire as a research method will be discussed in another article; but as results are known to depend to a great extent on the way in which questions are asked, the full question and alternative answers provided will be given in each case.

In 1957 there was considerable interest among students in the subject of emigration, and the reasons for it are no less today. A large number of doctors were known to be emigrating, not a few of them being Registrars who found difficulty in getting Consultant posts in England. Therefore those who intended to go in for specialist work were liable to find a pressure on them to go abroad. Moreover the conditions of

General Practice had changed under the Health Service, and there was a possibility that the aspiring Family Doctor would look abroad to find a type of practice which he could no longer have here. Interest was further stimulated by a series of excellent articles in the *Journal* by practitioners overseas.

It was obvious that very few, if any, students would have already made definite plans for emigrating, or indeed would have very definite ideas on the subject. Therefore the object of the survey was to assess the extent to which students had considered emigration as a possibility; and to get from those who had in fact seriously considered it some idea of why and where they wanted to go, and to find out what sort of people they were.

We have left out the answers of the thirty-five foreign and Commonwealth students, which leaves a total of 343.

Interest in Emigration

The first two questions in the series on emigration (Nos. 41 and 42 of the Questionnaire) were designed to discover the main attitudes to the general prospect of emigration:

Have you considered seriously the possibility of emigrating?

	Total	%
Yes	231	67
No	112	33

If your answer to the last question is yes, have you ...

	Total	%
Decided against emigrating	25	7
Decided to emigrate without or before obtaining specialist degrees ...	5	1
Decided to emigrate after obtaining specialist degrees	15	4
Remained undecided ...	60	18
Postponed your decision until after qualifying ...	102	30
Postponed your decision until after you have specialist degrees ...	24	7

Thus it appeared that a surprisingly large number of 231 students (67 per cent) had seriously considered the possibility of

emigrating. 25 of these had decided not to emigrate. 20 had decided to emigrate either before or after taking a specialist degree (17 men and 3 women). 60 had remained undecided about it and 126 had postponed the decision until later.

For the sake of simplicity these 231 students will be considered in three groups:

	No.	%
Group I: Decided not to emigrate	25	11
Group II: Decided to emigrate	20	9
Group III: Undecided or postponed the decision	186	80

The Country of choice

Only groups II and III are of interest in relation to the next question.

If you were to emigrate, to which country would you go?

	Group II	Group III	Total %
Canada	6	57	30
Australia	2	20	10
New Zealand	3	32	17
Union of South Africa ...	0	5	2
British colony or protectorate in Africa ...	4	30	16
Other British colony or protectorate	1	7	4
Other Commonwealth country	0	4	2
U.S.A.	3	14	7
Other foreign country ...	2	21	11

Canada easily heads the list, with New Zealand and the African colonies a fair way behind.

Evaluation of prospects

The next question was intended as an objective assessment of the seriousness with which emigration had been considered; and also as a means of determining the sources of information used in making the appreciation.

Have you, concerning the country of your choice ...

	Group		
	I	II	III
Talked to people with medical experience of the country ...	3	73	82
Visited it yourself ...	5	6	23
Sought information about it from an official body ...	1	5	32
Read articles about practice in the country ...	4	12	78
None of these ...	16	1	57

This shows that as many as 38 students had gone so far as to seek official information (and a further 5 who stated that they had not considered emigration seriously had also done this!). Personal contact with doctors from abroad was the main source of information, but articles on the subject were also of value.

It appears that an unsatisfactory investigation of prospects abroad was not a major reason for the decision not to emigrate.

Reasons for emigrating

The following are possible reasons for emigrating. Mark any of them which are important in influencing you to favour emigration, ...

	II	III	Total %
Better financial prospects and standard of living abroad ...	11	110	59
Better environment in which to bring up children ...	9	53	30
More private practice ...	3	28	15
Travel and adventure ...	10	90	49
Greater professional freedom	11	65	37
Greater possibility of combining specialist and general practice ...	7	56	31
Missionary work ...	2	24	13
Less overcrowding in the branch of medicine you wish to enter ...	9	73	40
Greater chance of becoming a consultant ...	3	27	15

What is the most important reason for which you would emigrate?

In answers to this question, the suggested reasons were given in the same proportions as for the previous question, and will not

be presented in detail. However, 61 students gave written answers, approximately as follows:

Too much red tape in Great Britain (7)
 I would be more use abroad (5)
 To escape from possible Socialism (4)
 To join relations abroad (4)
 More opportunity abroad (4)
 Politics (3)
 Overcrowding here (3)

Two gave each of the following:

This country is boring,
 The weather,
 The National Health Service,
 To live in a free community,
 Higher standard of living,
 The potentiality of an underdeveloped race,
 For a change.

And one each of the remainder:

To work with the W.H.O.,
 I dislike conditions in G.B.,
 Healthy environment,
 Better facilities for research,
 Angry young man,
 To gain experience,
 Security for wife and family,
 To get a decent job,
 Liking for other countries,
 Uncertainty here,
 To observe foreign methods,
 To live in a young country,
 Room to experiment in General Practice.

Financial considerations appeared to be the most cogent factor, with travel and adventure a close second (when the ladies are taken alone this order is reversed). Private practice did not seem to be much of a lure, while the mission field beckoned a small but significant group. Although none of the suggested answers expressed a primary dissatisfaction with Great Britain, 28 students gave this in written form in one way or another.

Who want to emigrate?

The main views on emigration were compared with a number of other answers, but on the whole results failed to show up any significant correlation. A slightly greater proportion of public school boys had seriously considered emigration (156 out of 221) than grammar school boys (66 out of 111). Four out of thirty-five students engaged to be married had decided to emigrate, and none not to emigrate, which suggests that

wedding plans and a desire to emigrate are in some way associated. Stage of training, university, political preference, or a medical parent did not appear to affect the issue, nor did the aspiration to any particular branch of medicine. As was expected, those who had never been abroad were less decided in their views.

Emigration statistics

To introduce a little reality into this analysis of aspiration, we will present a few figures on the actual number of doctors emigrating from this country. Unfortunately, these figures are extremely hard to come by, and the lack of information on this subject is perhaps one of the most surprising facts to be unearthed by this survey. The B.M.A. and the G.M.C. were unable to provide any statistics at all, and in fact the only document of any value is the Fifth Report of the Oversea Migration Board, published in March 1960.

This report quotes figures supplied by the Board of Trade for doctors emigrating by sea in 1958; a total of 984 doctors (838 men and 146 women) left this country by *long sea voyage* in 1958 with the intention of staying more than one year abroad. Since a fifth of all emigration takes place by air, and a larger proportion of professional men travel in this way, one might safely add a quarter to this figure making a rough total of 1,230. This, of course, includes many who intend to come back in a little over a year, and it also includes foreign doctors returning home after spending a few years here.

To which countries did these doctors go? We have no direct information on this point, but from a consideration of Commonwealth and Board of Trade statistics we can get a rough idea of the destination of emigrants as a whole:

	%
Canada	17.5
Australia	31.0
New Zealand	9.5
Federation of Rhodesia and Nyasaland	5.0
Other Commonwealth countries and British Colonial Territories and Protectorates	17.0
Foreign countries	16.5
	<hr/> 100.0 <hr/>

These figures relate to the year 1958 when there was a recession in Canada. In 1957 Canada had four times as many immigrants from the United Kingdom.

We do know that in 1958 the United Kingdom supplied 51 per cent of all Physicians and Surgeons immigrating to Canada (compared to 20 per cent of her total immigrants) but unfortunately we do not know the absolute figures.

The published figures give only a very rough idea of the number of British doctors emigrating, and of the countries to which they go.

Summary

In answer to the questions on emigration in the Questionnaire circulated to students in December 1957, 231 of them (67 per cent) said that they had seriously considered the possibility of emigrating. Of these 20 (9 per cent) had decided to emigrate, 25 (11 per cent) had decided not to emigrate, and 186 (80 per cent) had remained undecided or had postponed making a decision.

Canada was the most popular country to emigrate to, followed by New Zealand and the African colonies.

"Better financial prospects and standard of living abroad" was the most favoured reason for emigrating; the second was "travel and adventure".

Interest in emigration was slightly greater in ex-public schoolboys than in those who had been otherwise educated. 38 students had sought information about emigration from an official source.

The few available statistics on medical emigration are discussed; in 1958 about 1,230 doctors emigrated from the United Kingdom, and most of these probably went to Australia and Canada.

* * *

AN ADEN JOURNEY

by Alfred Flighswatt

ALL the best travel stories begin at home, with a scene on a bus in London, or a telegram received in the middle of a darts match in a country pub. This one begins on a chilly Sunday morning in September. I had been invited to lunch by a senior official from the Aden Protectorate, and we sat on faded leather upholstery and discussed my future programme. "I wouldn't advise that area", he said to one suggestion of mine. "I was shot at last time I was there." The object of my visit was to be a study of malaria and mosquitoes. There wasn't much we could fix at that range, so I sipped my sherry and left my plans unmade.

I left London a few days later in a Britannia, which flew us more speedily and more comfortably than any other plane I'd experienced. We landed at Khartoum at dawn, and later in the morning we got to our destination. That afternoon I was taken out swimming. It was pleasant to float around the buoyant waters of the Gulf of Aden and to remember that just 24 hours previously I had been drinking mild and bitter with the family in London.

On the 23rd we left to spend a night at a small station in the neighbouring state of Abiyan. The first thirty miles of the route lay along the shores of the gulf, and the road consisted of the top 20 yards below high water mark. The beach was littered with the bodies of dead fish, and the driver told us that this happened regularly at that time of year, which discouraged us from any further speculation on the effects of radioactive fallout in the depths of the Arabian Sea. On arrival at Abiyan we visited a hospital walled off from the desert, where I learnt that one in three of their in-patients were suffering from malaria. We inspected houses in the irrigated area that were festooned with gorged mosquitoes and we sat at night and caught them as they came in to bite.

A day or two later we flew to Mukheiras by the early morning plane. On the way we passed over the Upper Yafi territory, a country I would dearly like to have visited. However I was assured that no Englishman had ever been there, and that the chances of emerging alive were deplorably low. At

that time an outbreak of smallpox was known to be raging among the Yafi people, but the political authorities had firmly forbidden the enthusiastic young public health officer concerned from entertaining any ideas of personal intervention.

Mukheiras is only two miles from the Yemen border, and is one of the main bases from which intrusions by Yemeni tribesmen are repelled. It stands on a plateau which is a contrast of black rocky hills and shallow green wadis. The greenness is mostly due to fields of millet, which are watered by an ingenious system of irrigation from wells, using camels as a source of power. In a stream I found some *Simulium* (black flies), the first I think to be recorded in this otherwise arid country. In the evening I went out to a neighbouring village to see what mosquitoes could be caught as they came in to bite. In a very short time I was invited over to drink tea with one of the villagers, and since it wasn't dark yet I readily agreed. We passed through a hole in a mud wall, across a courtyard, up some rudimentary steps into one of the first storey chambers. After several cups of very sweet tea spiced with cinnamon I left and went off to do some catches outside. We caught nothing there, so we tried in one or two houses to which we were readily admitted. While this was going on, some Yemeni tribesmen loosed off a couple of shots in our direction, and when the time came to return, I was earnestly requested to put out my torch, and two armed village guards escorted me back to camp. From then on I abandoned night work in that district.

On the 26th we flew off in an R.A.F. Valetta to Attaq, about 100 miles to the east. Attaq boasts a fort standing in the middle of a sandy plain, built along the best Beau Geste lines. There is also a small tented army camp occupied by a detachment of Levies and a few odd British troops, clad in nothing but a pair of shorts and, like myself, dreaming of nothing but pints of mild and bitter. They had my sympathy.

We left Attaq in a battered old three-ton Bedford, and bumped and ground up a wide barren valley. After an uncomfortable couple

of hours, the road wound through a cleft in the hills, and we emerged into a narrow fertile valley, the Wadi Yeshbum, with the town Sa'id at its head. All the houses in Sa'id, as in all the towns and villages of the Aulaqi country are simply mud sky-scrapers, tall square buildings with turrets on the roofs and three or four sets of rooms jammed one on top of the other. The rooms have high ceilings and narrow slits of windows, and the massive thickness of the walls evidently serves to protect the occupants both from the midday heat and from the chance of stray bullets.

On the first day we lunched with the Emir. The party included the young British Health Adviser, myself, the Arab political officer, our servants, the Emir and an aged African. "He is my slave", said the Emir "but I treat him like a brother". We left our shoes at the door and sat down on rugs arranged along the sides of the room. My companion had previously explained to me the two important conventions that must be observed; food must be eaten with the right hand only, and the soles of your feet must not be directed at anyone—in other words you may never stretch your legs out comfortably in front of you. The Emir served the food himself. There is quite a knack in eating, if not delicately, then at least efficiently, with one's hand. My first attempts were deplorably clumsy, but by the second meal I was spreading less of it over my face, my knees and the mat. From time to time our host would pass across some specially choice pieces of meat, which I had to accept even though they usually arrived when I had decided I had eaten enough and was attempting to withdraw from the fray. Tinned fruit was served—doubtless for our benefit—and this was followed by an awkward interval during which one was left wondering what on earth to do with a greasy right hand. However, soon afterwards, the slave, who by then was being treated as very much the younger brother, came round with a bowl and soap and water, and we were able to settle down more comfortably on our haunches. A curious brown liquid, described as coffee but tasting like a hot infusion of ginger, was then handed round, followed by several small cups of the usual spiced tea. The political officer then gave us the cue to go, and after he had made a little speech on our behalf, we replaced our shoes and left. At the door I produced my two words

of Arabic meaning, I hoped, "Thank you very much", to which the Emir replied, a little ambiguously I thought. "Please do not thank me. It was a duty".

The Protectorate is an incredible place. You are not permitted to walk around the country without an escort of two or three armed guards. One day I decided to cheat my jailers, and slipped off up the rocky hillside behind my quarters. For a time I enjoyed the solitude and barrenness of it all, but I was soon startled to see a ring of stealthy figures closing in on me. Their shouts soon proclaimed that they were my own guards calling to their officer that they had found me. On my return I received a respectful reprimand from him. "In this country", he explained, "people like to shoot at strangers, just for fun." I was perfectly prepared to believe it. The front of the rest house where I stayed was pitted with bullet holes, dating, so I was told, from the previous year when the opposing political faction had crossed the tenuous line that separated "loyal" from "dissident" tribesmen, and kept up a regular nightly sniping of the house whenever the British Political Adviser was there.

It is a wonder that, quite apart from the people, any bird or animal is left alive in the country. I was out another day with my escort who were more than usually boyish. A magnificent eagle escaped destruction by shifting off its perch while the first trigger pressure was being taken. Farther on, an eagle owl that had ventured out of hiding was pointed out to us by a passing stranger. The unfortunate bird sat blinking in the sunlight while bullets (at something like 2s. 6d. a time) smacked into the rocks around it. A glancing blow eventually brought it tumbling down the rocks to fall at our feet alive and still blinking. My escort then amused themselves by prodding and teasing it, much as small boys will play with something that is too fierce to handle.

I spent an energetic week up and down the sandy river bed of the Wadi Yeshbum. The main valley at that season was as dry as the desert itself, but up the gorges and side valleys there was always an abundance of pools and little streams that formed the foci from which malaria and bilharzia were contracted. I suggested once that I should take an escort with me and see what could be caught biting at night in one of these valleys. The plan was promptly vetoed by

the Arab Political Officer. The Chief Minister of State, when he heard about it, said it *could* be arranged but that guards would have to be sent to occupy the neighbouring peaks first; so I let the matter drop.

Another excursion took me to Beihan. This had been the centre of much recent skirmishing with the Yemenis, and at that time there was a battalion of Levies stationed there. The Levies produced a 3-ton truck for me and an escort, and sent me off to their outpost, Negd el Masr, 20 miles away. There was one British officer there and a number of Levies. There had been no shooting in the valley for a couple of weeks so I was told that, in the daytime, I could go anywhere I wanted provided I kept away from the border, which lay about half a mile beyond the camp. I visited it one morning ostensibly to do some catches, but in reality to have a good look across into the Yemen. Breakfast was laid on for me after which the guards described their prowess in recent actions; photographs were posed to show them shooting imaginary Yemenis, and only after considerable delays did I get any work done. The fighting at that time was an exaggeration of normal tribal feuds, instigated by the Yemenis on one side, and resisted by the Sultan of Beihan, with our support, on the other. It was rumoured that, when the Yemenis showed signs of losing heart in that sector, the local Protectorate tribes would fire over the top of the army camp to make sure that we did not evacuate the area.

The work in the valley was unusually profitable. At night the place hummed with mosquitoes, which proved to be of a little known variety. One evening I obtained permission from the C.O. to visit the nearest village after dark. We were about to depart when the senior Arab warrant officer came into the mess and said, "Sir, I think it is very unwise to proceed. They may see the lights of the car going out and lie in wait for its return". Eventually it was agreed that we could sally forth provided the lights of the car were put out. The moon was not yet up when we left, so we set off in the darkness.

Nothing happened, of course. In the village we were greeted with enthusiasm and led upstairs to a room full of old men sitting round smoking a hubble-bubble. I issued test tubes to the small boys of the house, and they hopped from crone to crone picking off anything that had six legs. After a

time one of the men got up and, taking a couple of tubes, announced that he would see what there was in the harem. Giggles from a neighbouring room suggested that he was actively engaged, but as he came back empty-handed I was left in doubt as to the single minded nature of his search. We returned to the camp in bright moonlight, feeling as conspicuous as a stage hand caught before the audience as the curtain goes up. Once near the camp the worry remained as to whether the guards would remember that we were out and would refrain from opening up on us.

The last of my visits was to Mukalla, the main port of the Eastern Protectorate or Hadhramaut. Eastern Aden is very different from the west. It is above all peaceful. Mukalla is an old Arab town with fine stone houses encircling a wide bay. Beyond the town the bay is fringed with sand dunes; behind, there are jagged red mountains which, with the intense blue of the sea and the white washed houses between, make a dazzling contrast in colour.

The four days I had in Hadhramaut were busy ones, beginning with breakfast at six, and ending with a race against time to get through the field work before it got dark soon after half-past five in the evening. Much of my time was spent in the brackish lagoons along the shore. Apart from these there was little to detain us apart from the pelicans paddling in the sea, the regiments of fiddler crabs that scuttled out of the way of the advancing car, and in one place the whitened bones of a whale and in another the battered skeleton of a plane. The lagoons are known to the few Englishmen in the country as profitable spots for shooting duck. To myself, they are memorable as the home, in little pools encrusted with salt, of a mosquito that somehow survived into the second half of the twentieth century without the dignity of a scientific name.

On my last evening in Mukalla we were invited out to dinner by the state customs officer, a Pakistani. The dinner proved to be an enormous affair. My English host insisted on issuing me with a *futa*—the long Arab sarong—and then added insult to injury by producing a pair of nylon underpants with all that that implied as to my experience of squatting on the floor. I complied with his wishes and followed him into the house, trying not to trip over my skirt as we climbed upstairs. The party was held

on the roof. There must have been sixty people present, including the British Political Adviser, in the same attire as ourselves, the Prime Minister of the State (himself a Pakistani), the Sultan's 12-year old son representing his father, and three English women. We all sat down to dinner on Persian rugs with which the entire roof had been covered for the occasion. The food was laid out in rows of dishes spread on the floor on tablecloths 40 feet long, and when it had been served there was a dignified rush to get the best places. We plunged our hands into communal bowls in appropriate manner, and as soon as we had finished, our places were taken by the servants and hangers-on. And no doubt, if there was anything left after that, the remnants were gathered and sent down to the women and children.

Next day I flew off to Aden, clasping a precious bundle of live mosquitoes. My solicitude was in vain since they were all dead on arrival. Two days later I was back in Africa in the damp forested hills of the Tanganyika coast, a contrast as great as any I had experienced during the previous six weeks.

Epilogue

In the annual report of the Aden Protectorate Health Service for 1957 the following note appeared. I quote it in its entirety:

"Section 12. Noxious Animal Life."

73. Dr. Flighswatt of the East African Institute of Malaria and Vector borne Diseases, Amani, Tanganyika, spent a month mostly in the West.

LETTER TO THE EDITOR

Dear Sir,

In the July issue of the *Journal* you have published a number of interesting statistical analyses of student opinion in relation to aspects of medical education.

With regard to teaching in particular, it is more than possible that the conclusions drawn or implied are fallacious. Student opinion is subjective rather than objective and invidious comparison between departments may be explained, partly at least, in terms of student attitude towards those departments and the subjects taught there.

In my experience it is unusual for a medical student, even in his final year, to have any appreciation of the value of a knowledge of pathology in relation to his over-all medical education. The realization that this subject is the key to clinical medicine only comes to him when he is faced

with his final examinations, or even in his next year when he is busy bridging the gap between his theoretical knowledge and the practical application of it.

In the departments of bacteriology and pathology there are individual members of the staff whose value as lecturers is well recognised in other parts of these islands and abroad, if not at St. Bartholomew's. Lectures and demonstrations in a medical school have no higher value than that of giving perspective and emphasis. The facts are available in text books.

In the final analysis the student is, in fact, *self-taught* and it is high time that the Bart's undergraduate recognised the difference between teaching and learning.

Yours Truly,
Donald Fraser

73, Harley Street, W.1.

BOOK REVIEWS

FURNEAUX'S HUMAN PHYSIOLOGY: The Nurses' Edition, by William A.M. Smart (1960). Published by Longman's. Price 13s. 6d.

This textbook has been thoroughly revised and brought up to date, especially the sections on ligaments, cartilages and joints.

It is a book which makes interesting and informative reading especially to a nurse who has already a basic knowledge of Anatomy and Physiology. However, it is not an easy book for quick reference and contains more detail than is necessary for the Preliminary State Examination.

The illustrations and diagrams are clearly and easily understood. A number from the previous edition have been replaced by modern ones.

This book should be read by trained nurses who require more detailed information on physiology throughout their career.

J.G.

FAMILY PLANNING. J. F. Robinson, M.B., Ch.B. E. & S. Livingstone. Price 3s. 6d.

This sensible book gives concise and clear advice on modern methods of birth control. The illustrations are simple and good, the text not technical—and should be easy to understand by an intelligent layman. There are some rational arguments on the benefits of Family Planning and this book will provide adequate information to all those interested.

J.D.P.

AN APPROACH TO OCCUPATIONAL THERAPY—by Mary S. Jones. Butterworths. Price 42s. pp245.

To quote the author of "An Approach to Occupational Therapy", the work at Farnham Park is the specialised treatment of the short term patient with the expectancy of a quick return to a normal life in a professional or industrial capacity.

In this book Mrs. Jones has succeeded in showing the relationship and co-operation between the various departments concerned with the treatment of the patients at Farnham Park, whilst discussing in detail only the work carried out in the Occupational Therapy Department.

The author has shown us how each patient is approached and assessed both physically and mentally. She then gives detailed descriptions of the various pieces of equipment in use in the Occupational Therapy Department, together with excellent diagrams and photographs, besides clearly showing the movements involved in the use of the equipment and the subsequent therapeutic value. These descriptions also apply to the outdoor activities used, such as gardening, log-sawing, etc.

This book will be of great value, not only to Occupational Therapists and those working in Physical Medicine Departments, but also to anyone who has interest in the complete rehabilitation of the patient after his discharge from hospital.

P.M.A.

LIFE'S LONG JOURNEY—by Kenneth Walker. Gollanz. Price 21s.

In this book a distinguished scientist and surgeon considers the effect of science and the "scientific" attitude to life on our understanding of man, his beliefs, and the moral, political and economic problems which confront him. Mr. Walker states in his preface, "this book is the story of the long journey made by life since it first appeared on this planet in the simplest single cell form, many millions of years ago". But the author does not give us another history of evolution; he is more concerned with the nature of life, as the quotation, from G. Lowes Dickinson (which appears twice in the text) indicates:

"Man is in the making, but henceforth he must make himself. To that point nature has led him out of the primaevial slime. She has given him limbs, she has given him brain, she has given him the rudiment of a soul. Now it is for him to make or mar that splendid torso. Let him look no more to her for aid; for it is her will to create one who has the power to create himself. If he fails, she fails; back again goes the metal to the pot, and the great process begins anew. If he succeeds, he succeeds alone. His fate is in his own hands."

In developing his thesis that mankind's future depends upon the primacy of personal religion *vis à vis* the 19th Century scientific attitude to life, the author quotes extensively and powerfully; this book obviously reflects a life-time's reading and research, followed by study and reflection. The author is not portentous, and has the gift (so often denied to philosophers and theologians) of writing on intellectual issues in a sober, matter-of-fact way, without solemnity or obscurity. His twelve chapters are almost miniature books, full of interesting facts, ideas and discussion.

After preliminary chapters in which he attempts to define the place of scientific thought in our thinking and the contributions to scientific method of Galileo, Frances Bacon and Locke, Mr. Walker deals with the assumption that the human mind is objective in its outlook, and arrives at its conclusions without being deflected from the truth by any innate bias, discussing (with support from G. M. Tyrell and Bergson) the conditioning to which man's mind is subject.

The chapters on evolution contain a masterly summary of the development of Charles Darwin's thought and the controversy which followed the publication of "The Origin of Species", and a fascinating survey of geology and pre-history. Passing glances at the psychologist Gurdieff whet the appetite for more.

Briefly, the author concludes that evolution cannot be explained or accounted for in terms only of chance, mechanism or natural selection: it is impossible to incorporate the wealth of thought which he displays in a brief summary.

For the layman (and Mr. Walker claims to be writing for the general reader rather than the specialist) the last three chapters are (perhaps) the

most valuable and stimulating: they are headed; "Man's Political Future"; "The Scientist's view of Man's Future"; and "Where will the Long Journey End?"

Among the topics in this section are the world wide shortage of food, the problems of the genetically unfit, the expansion of China—"According to reports of travellers returning from Communist China, maps predicting the future are to be found in Peking which place the limits of the Yellow Empire somewhere west of Moscow and east of Berlin, in approximately the same latitudes as the frontier marked out in the same latitudes as the frontier marked out in the thirteenth century by the Mongolian Conqueror Ghangis Khan."

We find the opinions of H. G. Wells (who never claimed to be a scientist but is included as being keenly interested in man's future) alongside William James, Julian Huxley and Alex Carrel.

Finally the author deals with the role of religion—in the wider sense of that much abused term—and suggests that it is to religion that "man will have to turn for help if he is to evolve any further, for religion affects the whole of man and not merely his reason". He is convinced of the validity of religious experience, and comments on the complete agreement between those who have used the methods prescribed by religion; "It matters little whether the person reporting on their use be a Christian, a Vedontist, a Buddhist, a Sufi or an ordinary Moslem for it is obvious that he has obtained from their employment similar results".

What is the cause of the rapid decline of religion in the West?

Mr. Walker states that one factor may be the long term rhythm in man's thinking, the swing between materialism and idealism noted by historians; another factor may be of a social nature (here the author quotes a writer in *Hibbert's Journal*)—the rift between institutional religion and the proletariat which goes back to the Industrial Revolution. It is certainly true that in the age of the affluent society organised Christianity has failed to engage with the most typical members of this society, the technologist and the industrial workers.

Arnold Toynbee's prediction that the Western World will adopt what he calls an "oriental religion" by which he means "the Christian religion that came to the Greeks and Romans from Palestine with one or two elements of traditional Christianity discarded or replaced by a new element from India" is quoted with approval.

Perhaps religion syncretism will regain ground in the future, but if it does we should not forget that such a viewpoint in effect denies the claim of certain religions, Christianity pre-eminently among them, that they stand on certain historical events—for the Christian, faith is a compelling divine gift—for the student of religions it is a matter for discussion.

In an epilogue Mr. Walker returns to Gurdieff's teaching as a further aid to man's evolution apart from those provided by religion. Because man's "knowing" has so disastrously outstripped his "being" it is necessary to achieve a higher level of consciousness.

In our contemporary situation concludes Mr. Walker we can derive comfort and a sense of perspective "by viewing all passing events under the aspects of eternity".

This same volume, disturbing and yet stimulating, written with authority deserves to be widely read, and should contribute to a new quality of life which our affluent society needs. It is a commentary on the words of the Frenchman, Pierre Teilhard de Chardin (p. 280 of "The Phenomenon of Man") "when mankind has once realised that its first function is to penetrate, intellectually unify, and harness the energies which surround it in order still further to understand and master them, there will no longer be any danger of running into an upper limit of its florescence".

R.H.A.

DeWEESE & SAUNDERS: TEXTBOOK OF OTOLARYNGOLOGY. (Henry Kimpton). Price 65s.

On opening this book the reader should remind himself that the American language is not the same as that spoken on this side of the Atlantic. Perhaps then the style would not appear to be "heavy going".

From the students' point of view (and the foreword recommends the text to students and general practitioners) its reading would be unwise as it could only be muddling; too many American methods in surgery differ from ours and treatments vary considerably.

Most of the diagrams and photographs, notably those by Dr. Hollinger, are excellent, and there are one or two hints that a trainee otolaryngologist could find "profitable"—in fact if such a man had time to spare and could overlook the verbose style; he would also find some American methods surprising (e.g. the recommendation of local anaesthesia as the best for tonsillectomy). But for students such clinical descriptions as "The patient recovered without treatment, except reassurance, and then relapsed. He had no symptoms." could surely not help to gain an M.B.

A.F.

CHRISTMAS CARDS

Journal Christmas Cards will be printed again this year. Cards depicting the Henry VIII window in the Great Hall will be sold at 4½d. each (including envelopes) Orders will be taken by the Manager of the Journal. Please write placing an order as early as possible.

SPORTS NEWS

Viewpoint

Although this is not the number in which the Hospital pays tribute to Sir James Paterson Ross on his retirement, it is better late than never to mention the great interest Sir James has always shown in the sporting activities of the Hospital.

He has been both President and Vice-president of a great number of clubs, and this has been more than a mere nominal interest. In spite of what must have been overpowering commitments from the Hospital and the Royal College of Surgeons, he often went to great lengths to keep himself up to date with events in the clubs with which he was connected. The Cricket Club, in particular, is very grateful for the great help and attention he has given, in the 12 years in which he has been a Vice-President.

One of the clubs which has been having a remarkably successful year in a very unobtrusive manner, is the Sailing Club. During this summer, it has won a great number of trophies, the reports of which appear in this issue. These have not all been in United Hospital events. Perhaps the greatest achievement of all was the Ariel Cup, which was an event open to the country, won during Burnham week recently. Most of the successes have been due to Bill Fischer, and the club is lucky indeed to have a helmsman of his class. But credit must also be given to all others who have taken part.

Sailing Club 1959-1960

Under the auspices of our Commodore, Mr. Alment, to whom we are grateful for his active participation while still with us, and his good wishes, now that has left London, the club has had a successful year—success, that is, not only in competition, but in consolidation.

Since it is customary to direct attention to the least spectacular—that is not to say the least important—first, and thence through events of more immediate charm to a final apocalyptic event, thus hoping to instil a sense of impending climax to the reader, we will first consider what consolidation has taken place.

Surely one of the tests of the health of a club, like that of a gentleman, is to observe how it, or he, behaves when on its own. Admirable opportunity of this was afforded by the annual regatta held early in the year at the United Hospital's Club in Burnham. In spite of the strong N.E. wind which paradoxically brought sailing to a standstill on the second day, enough races were held to decide who should hold the various cups for the year. Races, that is, characterised by a gay disregard for the international rules and conventions.

The occasion of the regatta coincided with the annual dinner held in the Royal Burnham Yacht Club at which the cups were distributed.

Open Race—R. C. Birt

1960 Cup—D. M. Howells

Ladies' Race—Miss J. Hartley

In view of the support received at the regatta, it was decided that the time was ripe for a major attempt to spread the cult of yachting in the Hospital. Expeditions of novices have therefore been taken to the Welsh Harp by club missionaries, and it is hoped to continue these throughout the winter. In preparation for this the Club Firefly — Rahere — has been re-fitted in Charterhouse Square.

The winter series on the Welsh Harp has already been referred to in a previous issue of the Journal, but the ill-luck which followed us there was dispelled by the stronger winds of Burnham-on-Crouch, where, thanks to the superb helmsmanship of W. A. Fischer, the club has excelled itself, and swept the board, winning:

The Sherren Cup—held at Whitsun—

The Banister Cup—Inter Hospital series—

The Harvey-Wright Gold Bowl—on September 3rd.

Not content with this, W. G. Fischer went on to win the Ariel Cup—an open event for Sharpies—during Burnham Week.

Finally, the club would like to express its grateful thanks to the Students' Union for a capital grant to buy a new boat. A National Enterprise dinghy has been decided upon, and, complete with trailer it is hoped to enter a new class of racing.

D.H.O.

Rifle Club

St. Bartholomew's Hospital Prize Meeting

The Prize Meeting and the annual match for the E. B. T'Anson Staff v. Students Challenge Cup were held at Bisley on June 26th. Weather conditions were good, with only a moderate wind, and good light. The Benetfinck Challenge Cup was awarded this year on a dropped points handicap basis, the competitors being grouped according to their capabilities and experience. The staff team was strengthened by the addition of two past members of the Club.

H. J. Waring	
Challenge Cup:	A. M. Pollock 96
runner up:	A. A. Lewis 92
Benetfinck Challenge Cup:	A. M. Pollock 96
runner up:	Miss J. G. Stephan 94.8
Donegal Badge:	P. N. Riddle 91
E. B. T'Anson Challenge Cup:	The Students

The Students		The Staff	
A. M. Pollock	96	Mr. J. D. Hobday	96
P. N. Riddle	91	Mr. J. Elgood	91
A. M. Ward	91	Mr. G. L. Bourne	89
		Dr. F. T. J. Hobday	88
F. J. R. Hardy	90	Mr. G. R. Hobday	87
Miss Z. Gardner	87	Mr. H. Jackson	
M. T. Barton	79	Burrows	68
	534		519

N.R.A. United Hospitals Cup

The Hospitals Cup at the Imperial Meeting was shot for on Friday, July 4th. in heavy rain. Conditions were not easy but scores in general were high. The Hospital "A" team were unfortunate to be placed only third, behind The London and Guy's "A". The "B" team was placed fifth.

London Hospital "A"	379
Guy's Hospital "A"	376
St. Bartholomew's "A"	374
	200 500 600
A. M. Pollock ...	35 33 32 100
P. N. Riddle ...	33 34 31 98
Miss Z. Gardner	32 31 33 96
A. M. Ward ...	30 20 30 80

The full-bore season was finally closed with another match against the Staff, the match being held at Bisley on September 4th. Weather conditions for this, the last

match, were good, and the only rain came at the luncheon interval, and after shooting had finished for the day. The match, which consisted of 2 sighters and 10 to count at 200, and 2 sighters and 15 to count at 500, resulted in a narrow victory for the Students.

The Students		The Staff	
P. N. Riddle	116	Mr. G. L. Bourne	113
		Mr. G. F. Abercrombie	113
M. T. Barton	109	Mr. R. P. Ellis	113
A. M. Ward	108	Mr. H. Jackson	
A. M. Pollock	106	Burrows	103
Miss A. M. Holloway	102	Mr. R. C. Farrow	91
	541		533

The Small-bore Season 1960-61

With the loss of the rifle range in the Hospital after December of this year, it has been decided that the number of teams run by the Club will have to be reduced. Both Standing and Kneeling teams have been dropped, as has one of the Pistol teams, and a Lloyd Cup team.

The following teams are being entered this season:

United Hospitals Lloyd Cup: One team.

United Hospitals Tyro League: Two teams.

University of London Pistol League: One team.

National Short Range League: One team.

Browne Martin Competition: One team.

Chess Club

The Chess Club has had a fairly successful season. We have retained the Hospitals Cup and managed to stay in the 1st division of the University of London Chess League. Few people seem to realise that, apart from the invincible Ladies Hockey Club, we are the only club in the Hospital to have the Cup for the second year running.

In the league, after a poor start, the 1st team improved and made certain of its place in the league by defeating U.C.H. at the close of the season. In the Cup, we reached the final by beating St. George's easily and the London with difficulty. The final was contested with Guy's.

A good meal and a display of the Cup were calculated to rouse the fighting spirit of the teams and a very good match it turned out to be.

Bart's: D. J. P. Gray; G. Gardos (Capt.); P. M. Perry; R. Harrison; A. MacFarlane; R. Zeegan; were soon in trouble. In spite of Perry's spectacular win, which he achieved in excellent attacking style, quite early on, Bart's were 2-1 down after 1½ hours play. Then Gardos won though after a very exciting game to make the score 2-2, but the prospects in the remaining games were gloomy for Bart's. MacFarlane was struggling

against a strong attack and eventually succumbed. Gray, though attacking well, had already used up nearly all of the allowed 1½ hours and found himself in a very complicated position, but, with seconds to spare, Gray managed to get out of time trouble, avoiding disqualification, and went on to win.

The final result was 3-3. By eliminating the result of the bottom board, Bart's won the match and thus retained the Cup.

About 30 gentlemen have joined the Chess Club this year and special mention must be made of T. Harcup for his continued good play during the season.

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